


# SHORT-TIME COMPENSATION PLAN – APPLICATION FORM "A"

Vermont Department of Labor

1. EMPLOYER/COMPANY NAME & MAILING ADDRESS		2. UNIT NAME & WORK LOCATION	
		E-MAIL ADDRESS	
3. U.I. EMPLOYER ACCOUNT #		4. NAME & PHONE NUMBER OF EMPLOYER CONTACT PERSON	FAX NUMBER
5. APPLICATION TYPE 	Original Application <input type="checkbox"/>	Modification of Approved Plan by: <input type="checkbox"/> Adding Participants <input type="checkbox"/> Deleting Participants <input type="checkbox"/> Changing Work Hour Reductions	

## PLAN DATA

6. Total number of full-time & regular part-time employees in unit?																			
7a. Number of employees that would otherwise be totally laid off?																			
7b. For employees included in Item 7a, enter the number who regularly work the following hours per week, the total weekly hours for each category AND THEN ENTER ON THIS LINE THE SUM OF ALL THE CATEGORIES.  <table border="1"> <tr> <td>EMPLOYEES:</td> <td>No. _____</td> <td>No. _____</td> <td>No. _____</td> <td>No. _____</td> <td>= _____ (Equals 7a)</td> </tr> <tr> <td>HOURS/WEEK:</td> <td>x 30 Hours</td> <td>x 35 Hours</td> <td>x 40 Hours</td> <td>x Other _____</td> <td>(Grand Total</td> </tr> <tr> <td>TOTAL HRS/WEEK:</td> <td>= _____</td> <td>= _____</td> <td>= _____</td> <td>= _____</td> <td>Hours Per Week:)</td> </tr> </table>	EMPLOYEES:	No. _____	No. _____	No. _____	No. _____	= _____ (Equals 7a)	HOURS/WEEK:	x 30 Hours	x 35 Hours	x 40 Hours	x Other _____	(Grand Total	TOTAL HRS/WEEK:	= _____	= _____	= _____	= _____	Hours Per Week:)	Hours
EMPLOYEES:	No. _____	No. _____	No. _____	No. _____	= _____ (Equals 7a)														
HOURS/WEEK:	x 30 Hours	x 35 Hours	x 40 Hours	x Other _____	(Grand Total														
TOTAL HRS/WEEK:	= _____	= _____	= _____	= _____	Hours Per Week:)														
7c. Number of weeks that employees in Item 7a would otherwise be totally laid off? (Must equal at least 8 weeks, but not more than 26 weeks.)	Weeks																		
7d. Multiply Item 7b times Item 7c and enter results here and on line 8c.	Hours																		
8a. Number of employees in unit you plan to have working reduced hours? (Must be 10% or more of Item 6)																			
8b. COMPLETE FORM B and then enter the total of Form B column 9 on this line.	Hours																		
8c. Entered from Form A Line 7d.																			
8d. Divide Item 8c by Item 8b to obtain the number of weeks you plan or can project to work these employees on reduced hours. (Round to nearest full week and note that it must not exceed 26 weeks.)	Weeks																		
9. On what date (must be a Sunday) do you want this plan or modification to start?																			
10. On what date (must be a Saturday) do you want this plan to end? (Plan duration not more than six (6) months)																			
11. Describe how participants will be notified of plan and how you plan to work with them to implement it.																			
12. Describe how the fringe benefits of the participants will be affected by the planned reduction in work hours and wages.																			

13. I certify that the above information is correct and as follows:
- The employees in Items 6, 7a and 8a normally work at least 30 regular pay hours per week.
  - The hours shown in Item 7b exclude overtime pay hours and any in excess of 40 hours per week.
  - This plan has been agreed to by all collective bargaining agents representing all employee participants shown on the attached Application Form "B".
  - Each employee listed on Application Form "B" is a full-time or regular part-time employee of the employer.
  - The planned reduction in weekly hours for the employees listed on Application Form "B" is instead of layoffs that would result in at least as large a reduction in total work hours.
  - The normal weekly work hours of the employees will be reduced in accordance with the data shown on Application Form "B" with a corresponding reduction in wages.
  - We understand that the short-time compensation benefits paid under this plan will be charged to our experience rating period (or if a reimbursable employer, we will be assessed for those payments).
  - We understand that participation in the Short-Time Compensation Program will not affect our current unemployment tax rate, but that it could cause increases in our future rates.

Signed: \_\_\_\_\_  
(Must be Owner, Principle Officer or Authorized Representative)

Date: \_\_\_\_\_

Title: \_\_\_\_\_

SEE INSTRUCTIONS & DEFINITIONS ON REVERSE

B-148 (4/06)

## Completing and Submitting an Application for a Short-Time Compensation Plan

**General Comments:** The STC application consists of two parts. Form A is a description of how the employer wants to implement the plan. Form B is a list of the employees that the employer expects to have involved in the plan.

Because there are certain percentages that must be met in the plan, we recommend the completion of Form B before Form A. By doing so, you will find it easier to comply with the percentage and avoid unnecessary changes to Form A. Keep in mind that the following requirements must be met by the plan you submit:

1. The unit must consist of at least five full-time or regular part-time employees who normally work at least 30 hours per week. A "Sole Proprietor" of the business may not be included as one of the five participant employees of a qualifying unit.
2. The normal total hours of work for the unit cannot include any overtime nor any more than 40 hours for any of the employees in the unit.
3. The reduction percentage must be equal for all the employees listed on Form B and must be between 20% and 50%.
4. All participants listed on Form B must be monetarily eligible for regular unemployment benefits and it should be noted that approval of any STC plan is subject to revocation if any participant is later found to be ineligible.
5. At least 10% of the employees in the unit must participate in the plan.

We **recommend** that you make a photocopy of your complete application to retain in your files.

Send the original of the completed application forms (Forms A and B) to the STC Unit, Vermont Department of Labor, P.O. Box 189, Montpelier, Vermont 05601-0189.

We will review your application and respond to you in writing within 15 days of receipt of your application.

If your plan is rejected, we will indicate the reasons in our letter of rejection. You can make any necessary corrections and resubmit a plan.

Please note that all plans are subject to at least one compliance review by this department during the first three months of the plan. If that review indicates that an employer is not abiding by the terms of the approved plan and the statutory requirements for each plan, the Commissioner may revoke approval of the plan by notifying the employer in writing.

Also note that any approved plan will automatically be terminated on the effective date of any transfer of ownership of the legal business entity.

If you have questions or need assistance, please contact us at: 1-877-214-3331 and ask for an STC Representative.